LTC Recipients Are Eligible to Receive Behavioral Health Services

Many people believe Long Term Care recipients on the AHCCCS system are ineligible to receive behavioral health benefits. The truth is, if a client is enrolled with either LTC DD DES (110007) or DES DD LTC VD (550005) they are categorically eligible for the same behavioral health benefits as all other Title XIX and Title XXI recipients.

For questions on client eligibility information found on the Medifax system, the AHCCCS Website or the AHCCCS PMMIS system, providers may contact the following RBHA personnel between the hours of 8:00A.M. and 5:00P.M.:

CPSA	Member Services	(800) 771-9889 (520) 318-6946
EXCEL	Eligibility Manager	(928) 329-8995
NARBHA	Member Services	(800) 640-2123 (928) 774-7128
PGBHA	Eligibility Data Solutions	(480) 982-1317
Value Options	Enrollment	(602) 914-5800

Providers may call AHCCCS Customer Service at (800) 962-6690 between the hours of 5:00P.M. and 8:00A.M.

Intake Edits

Effective February 1, 2003, if a client ID is present on a new intake; it must match an existing client ID in the CIS system. If it does not match an existing client ID, it will be rejected by the system with error message, "Invalid client Identification."

New CIS Screen

A new screen has been added to your CIS menu called **Deleted Intake Inquiry**. This screen displays intakes that have been deleted to help facilitate elimination of overlapping intakes and duplicate client ID's. The format of the screen is the same as the Client Inquiry Screen and the search criteria options are the same.

Place of Service Code 99 Not For Emergency Transportation

Effective January 29, 2003, place of service code 99 will only be accepted as a valid code for non-emergency transportation. Emergency encounters with a place of service code 99 will not be accepted.

Top Monthly Pended Encounters

These edits continue to represent the majority of the pended encounter problems and may be sanctionable.

R600 – Medicare Coverage Indicated But Not Billed

Encounters are pending because the TPL file indicates the recipient has Medicare coverage, but the claim has been submitted with the Medicare fields blank. If the TPL file indicates a recipient has Medicare, claims must be submitted with a dollar amount. If the service is not a Medicare covered service, zero must be entered in the Medicare fields. A zero value indicates Medicare did not cover or denied the service.

The number of encounters pended for R600 are as follows:

CPSA 5	4,497
Value Options	2,426
CPSA 3	934
NARBHA	133
Excel	41

Z720–Exact Duplicate Found

Encounters are pending because at least one claim was found in the system that matches the pending claim. These claims need to be researched by the RBHA's to determine the cause for the exact duplicate. Multiple units of service for the same client on the same day should be combined. For example: If a client is seen for Peer Support twice in one day, W4048 should be billed on one claim with two units instead of two claims for one unit each.

The number of encounters pended for Z720 are as follows:

NARBHA	5,967
EXCEL	328
Value Options	152
CPSA 5	63
CPSA 3	5

P295-Service Provider Terminated During Service Date Span

Encounters are pending because the AHCCCS system indicates the billing provider's enrollment status as terminated prior to the billed dates of service. Providers can check their enrollment status in PMMIS PR070. The number of encounters pended for P295 are as follows:

Value Options	2,397
NARBHA	1,162
CPSA 5	69

ADHS/DBHS Office of Program Support Procedures Manual due soon
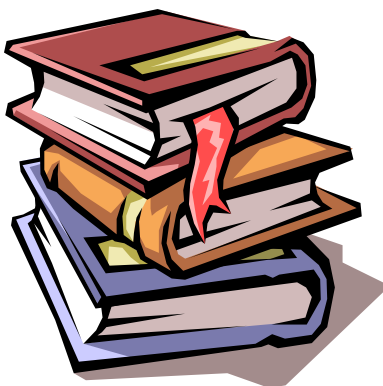
The ADHS/DBHS Office of Program Support has completed work on procedure manuals for the unit. All (T)RBHA's should receive two copies each within the next two weeks.

Fraud and Abuse Awareness

Please ensure providers and members know how and where to report fraud and abuse. It is our objective to be proactive in the prevention and detection of fraud and abuse in the Behavioral Health System. Those wanting to report possible fraudulent activity may do so by contacting their RBHA Fraud and Abuse Coordinator, or may report directly to Michael Carter (Fraud and Abuse Investigator, Division of Behavioral Health Services) at (602) 553-9075. Callers may remain anonymous.

Important Statistics

The following statistics regarding fraud and white-collar crime are from the 2002 Report to the Nation. This report, conducted by the Association of Fraud Examiners, provides the most detailed view yet of how occupational fraud affects organizations in the U.S. annually.

- It is estimated that 6% of revenues were lost in 2002 as a result of occupational fraud and abuse. Applied to the U.S. Gross Domestic Product, this translates to losses of approximately $600 billion, or about $4,500 per employee.

- Organizations with fraud hotlines cut their fraud losses by approximately 50% per scheme. Internal audits, external audits, and background checks also significantly reduce fraud losses.

- Small businesses are the most vulnerable to occupational fraud and abuse. The average scheme in a small business causes $127,500 in losses. The average scheme in the largest companies costs $97,000.

- The most common method for detecting occupational fraud is through tips from employees, customers, vendors and anonymous sources. The second most common method of discovery is by accident.

- The typical occupational fraud perpetrator is a first-time offender. Only 7% of occupational fraudsters in this study were known to have prior convictions for fraud-related offenses.

- All occupational frauds fall into one of three categories: Asset misappropriations, corruption or fraudulent statements.

- Over 80% of occupational fraud involves asset misappropriations. Cash is the targeted asset 90% of the time.

- Corruption schemes account for 13% of all occupational fraud and they cause over $500,000 in losses, on average.

- Fraudulent statements are the most costly form of occupational fraud with median losses of $4.25 million per scheme.

- Fraud committed by employees cause median losses of $60,000, while fraud committed by managers or executives cause median losses of $250,000. When managers and employees conspire in a fraud scheme, the median loss rises to $500,000.

- Losses caused by perpetrators older than 60 are 27 times higher than losses caused by employees 25 and younger.

- The average fraud scheme lasted 18 months before it was detected.

Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state.
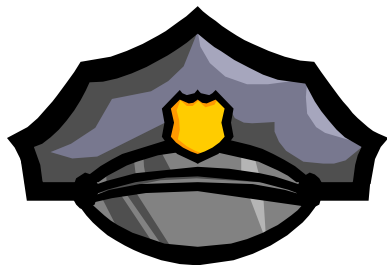
Edit Alerts

The Office of Program Support has created a process of informing RHBA IT personnel when new edits are added, or when edit changes occur. The notifications, called *Edit Alerts*, will be sent via fax and e-mail. Please be advised, The Office of Program Support will expend every effort to ensure an adequate notification period; However, it may not always be possible to notify RBHA staff a full 90 days prior to implementation.

New Hires

The Office of Program Support has hired two new Encounter Representatives. Dennis Burr will begin employment with the Office of Program Support effective February 10, 2003. Dennis has been with the state for five years, most recently with the Department of Health Services Division of Assurance and Licensure Service. Shameeka Johnson will begin effective February 18, 2003. Shameeka comes to us from the Department of Health Services Office of Bio-terrorism Preparedness and Epidemic Response. Please extend a warm welcome to both of our new co-workers.

"What's right is what's left if you do everything else wrong."
        -Robin Williams

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